Increasing Capacity and Impact - Diabetes Specialist Dietitian (DSD) Services in West Dorset

NHS Health Education England

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Aim

Increase user benefit from the existing DSD resource by: Using the year-long QI Fellowship resource to test ways to increase **capacity** (number of patients seen) and to see patients earlier in their diabetes 'journey' (**prevention vs treatment**).

Background

West Dorset's DSD service is provided by 1 full time plus 1 day/week part-time DSD against a benchmark of 6 full time DSDs; it sits within Secondary Care services at Dorset County Hospital. Existing services are focused on red RAG rated patients (who have higher level needs than can't be met in the community) as well as those newly diagnosed with type 2 diabetes (amber RAG rated). Continuing with this service model is not sustainable in the context of a growing diabetes population. The reasons for change reflect the Clinical Commissioning Group's (CCG) Sustainability and Transformation Plan (STP) for 'Diabetes Service Transformation' in Dorset and the NHS 'Right Care' ambitions.

Project Design

A **driver diagram** was used to set clear direction and parameters for the project. One GP Practice was selected for the trial; Royal Crescent Surgery, Weymouth.

Stakeholder engagement activities surveyed 31 patients and 19 staff on their views of the current service and their thoughts on what the service could offer.

Through these, new ways of working were identified and tested using **PDSA cycles** (Plan, Do, Study, Act). The trials related to **Type 2** diabetes only.

Changes Made

1:1 clinics → **Group** sessions

Dr/Nurse referral → **Universal*** Invitation

*483 group session invitations sent (*75% of Practice Type 2 diabetes population. 25% excluded e.g. housebound). Response rate was not predictable. Based on previous service access levels and expecting some increase, 3 group sessions were scheduled, with capacity for 10 patients per group.*

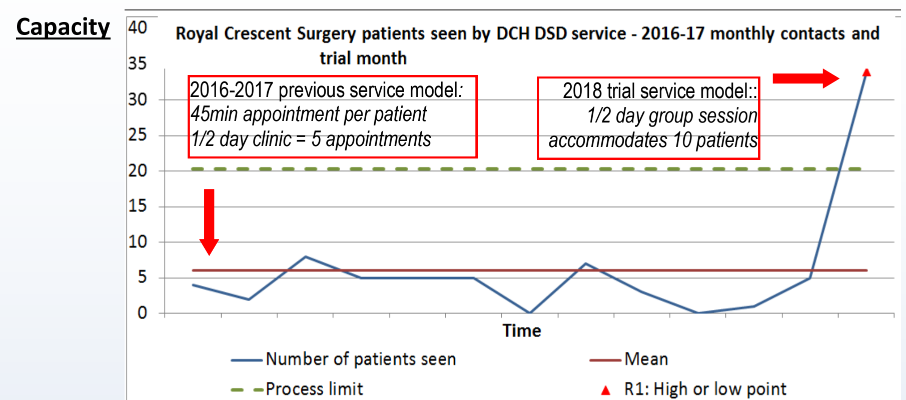
Integrated with hospital Teams → Integrated with hospital **and** GP teams

6 Practice clinics attended.

Outcome

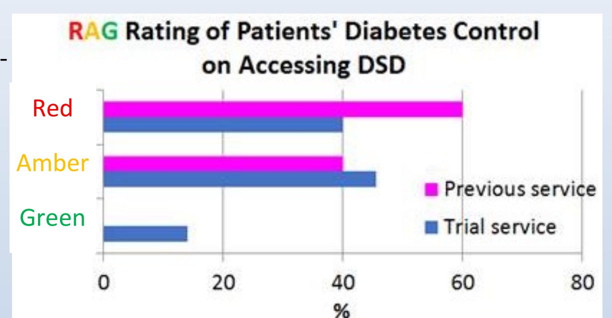
Number of patients accessing the service were counted. Patients and staff were surveyed to assess impact.

Capacity



139 people accepted the invitation (29% of the invited population); many more than anticipated. The trial offered capacity for 30.

Prevention vs Treatment



Diabetes clinical complications result from control above target for prolonged periods. The trial service accessed more patients with diabetes control in-target (green) or slightly above target (amber). Supporting people to stay in target **prevents** diabetes complications developing. Previous service accessed patients with diabetes control slightly above target (amber) or uncontrolled (red). Those patients needed **treatment** for existing poor control; a need which could have been prevented with earlier intervention.

Staff feedback on GP clinic involvement

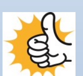
10/10 of GP and Practice Nurse responses said *yes, DSD involvement had a* ***positive effect*** *on their knowledge and confidence to provide diet/ lifestyle advice to patients.*

Balance measure - patient satisfaction

2 complaints (from patients unable to access the trial as groups were full). Friends & Family Test feedback from groups = 30 positive, 1 neutral

Sustainability

- Converting 1:1 clinics into group sessions makes service more sustainable.
- Attendance at Practice clinics is possible with some of the time 'saved' by replacing clinics with groups so is sustainable.
- Other Locality GP Practices are keen for the new service model. Roll-out of the trial format will increase service sustainability. The trial take-up rate information will help guide capacity modelling.
- Increased DSD profile in Primary Care and the success of the trial has attracted Primary Care funding, which will support roll out and sustainability.

The trialled service model appears successful and sustainable. 

Next Steps

- Roll out and integrate into the new Dorset Diabetes Transformation plans.
- Collect data to prove sustainability, clinical/financial/patient-centred outcomes.
- Repeat QI process for patients needing DSD input, who cannot access groups e.g. housebound.
- Share learning and consider application of learning outside of DSD services.

Lessons Learned

- Defining and revisiting the driver diagram is essential to keep on track.
- Service user engagement was easier and more beneficial than expected.
- Sessions can be shorter if each group serves only one medication type.
- Earlier implementation of PDSA cycles would have allowed data collection to demonstrate clinical impact (3 months needed before 'after' data available).
- More administrative support needed than anticipated.

Following QI methodology helps!

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS Dorset County Hospital NHS Foundation Trust